Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-11-3816-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: FEDERAL INSURANCE CO Box #: 17	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have years of denied medical from carrier and was permanently cut off 4-2010 while living in N.C. and could not dispute claim from there."

Amount in Dispute: $0.00

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The DWC-60 from the Requestor indicates that the Claimant is seeking reimbursement for medical bills which were denied to a health care provider… The EOBs in dispute in this matter shows that the medical bills were submitted by the health care providers Paul Raymond, D.C. and Injured Workers' Pharmacy, LLC. The medical bills were subsequently denied. Thus, in accordance with DWC Rule 133.307(b), each health care provider would be an appropriate requestor of a medical fee dispute. This rule does not allow the Claimant to seek dispute resolution on behalf of the health care provider. The claimant has not provided any documentation showing that she paid for this treatment, requested reimbursement of payment from Respondent, and was denied. With each medical bill in dispute, the health care provider was denied reimbursement, not the Claimant. In conclusion, this Medical Fee Dispute Resolution should be dismissed for all dates of service as the Claimant is not an appropriate party to this dispute in accordance with DWC Rule 133.307(b)."

Response Submitted by: Downs-Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
12/28/2010, 03/16/2011, 03/18/2011, 03/21/2011	Office Visits & Prescription Medicines	N/A	$0.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307(b)(3) sets out the procedures for injured workers to pursue a dispute involving an employee's request for reimbursement from the carrier of medical expenses paid by the employee.
2. 28 Tex. Admin. Code §133.270 sets out the procedures for injured workers to submit workers' compensation medical bills for reimbursement.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   EOBs were presented with the request for medical fee dispute resolution; however, the EOBs show that both the healthcare provider and pharmacy company sought reimbursement from the Insurance Carrier and were "denied per carrier" and "Based on the findings of a review organization."

Issues

1. Did the requestor incur out-of-pocket expenses for the services in dispute in accordance with 28 Tex. Admin. Code §133.270?
2. Is the requestor entitled to reimbursement?

Findings

1. The submitted EOBs show that both the healthcare provider and pharmacy company billed the Insurance Carrier for the services rendered. The injured employee, in this dispute, did not incur out-of-pocket expenses for office visits and prescription medications. Pursuant to 28 Tex. Admin. Code §133.307(e)(3)(B) the requestor is not a proper party to the dispute pursuant to subsection (b) of this section.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.